BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF	*	
ANNE ARUNDEL MEDICAL CENTER MENTAL HEALTH HOSPITAL	*	**Docket No. 16-02-2375**
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APPLICANT'S RESPONSE TO COMMENTS OF UNIVERSITY OF MARYLAND BALTIMORE WASHINGTON MEDICAL CENTER

The Applicant, Anne Arundel Medical Center, Inc. ("AAMC"), responds to the Comments filed by the University of Maryland Baltimore Washington Medical Center ("UM BWMC") regarding AAMC's Application for a Certificate of Need ("CON") to establish a special psychiatric hospital.

INTRODUCTION

AAMC proposes to establish a 16-bed mental health hospital for adults in a new building to be constructed on the campus where AAMC currently operates Pathways, its longstanding substance use and co-occurring disorders residential and outpatient treatment facility. The building would also house AAMC's psychiatric partial hospitalization program, and include shell space for the relocation and expansion AAMC's existing outpatient clinic and establishment of a new intensive outpatient clinic for children and adolescents, along with other outpatient mental health programs.[1] This project will enable AAMC to deliver a comprehensive and integrated

[1]AAMC established a psychiatric partial hospitalization program and an outpatient mental health clinic in advance of seeking to add inpatient capacity, the first health system in Anne Arundel County to do so. While there remains a critical need for additional inpatient capacity even with these community based programs, they are an important part of the continuum of care that will co-located with the inpatient unit at the Pathways location and enable the inpatient capacity to be its most effective. The partial hospitalization program will be relocated to the new building as part of this project, and the proposed shell space in the building will enable the relocation and expansion of the outpatient clinic for children and adolescents, and eventually the relocation of the adult outpatient clinic program from its current leased space.

mental health care program on a single campus that will incorporate inpatient psychiatric care, psychiatric partial hospitalization and other outpatient mental health programs, as well as referral and care coordination to community-based support services, to meet a critical need for these services in Anne Arundel County. See Application at 14-16.

Anne Arundel County is the third most populous county in the State and ranks fourth among all counties in the number of behavioral health emergency department (ED) visits, but is currently served by only one inpatient mental health unit, the 14-bed unit at UM BWMC. In Fiscal Year (FY) 2015, AAMC had to transfer a total of 1,173 patients from its ED for admission to a psychiatric unit (including 949 adult patients). None of these adult patients, however, could be transferred to UM BWMC's psychiatric unit, which admits patients almost exclusively from UM BWMC's own ED. According to HSCRC discharge data (Exhibit 1), in FY16, UM BWMC's unit did not accept any cases transferred from any other acute care hospital (inpatient or ED). Accordingly, patients in crisis who present at AAMC's ED must (after long wait times in the ED while an open bed is located) be transferred to facilities outside of Anne Arundel County, often up to an hour's drive time or longer from their home, hindering the involvement of their families and support networks in the acute episode of care as well as care transition and continuity of care after the patient returns home. See Application at 10-13.

With this project, the adult patients that must be transferred distances outside their communities and support networks for inpatient care will be able to receive care in Anne Arundel County. Equally importantly, these patients will receive inpatient care at a location

that will provide a continuum of mental health services in a single setting with the collaboration of other community health care providers to offer holistic and coordinated care, liaison services and the development of clinical pathways between and across a range of treatment providers. See Application at 14-16.

As a result of the integration of inpatient and outpatient care at a single site and efficiencies related to placement post-discharge, the average length of stay for the patients currently being transferred outside the County for inpatient care will be reduced by two days. See Application at 57.

AAMC's integrated care model will address a gap in mental health care services in Anne Arundel County that drives hospital admissions, readmissions and emergency department utilization by providing a well-coordinated, accessible, affordable and accountable system for delivery of mental health and substance use services. As a result, AAMC's project will generate a savings of over $3.3 million to the State. See Application at 55. AAMC's mental health hospital will operate as one of the lowest-cost inpatient psychiatric providers in the State on a case-mix adjusted basis, 33 percent below the statewide average.

Indeed, notwithstanding UM BWMC's self-congratulatory comments about the cost effectiveness of its hospital-based unit, the average charge per case at AAMC's mental health hospital will be 18% lower than the average charge per case within UM BWMC's unit. See Application, at 56.

UM BWMC acknowledges the need for the inpatient psychiatric capacity that AAMC seeks to provide, having made multiple public statements in recent years about the need for

additional mental health care services in Anne Arundel County.[2] UM BWMC collaborated with AAMC, County agencies and other stakeholders in developing the 2015 Anne Arundel County Community Health Needs Assessment (See Exhibit 1 to Application) ("CHNA") which highlights the critical mental health care needs in the County. The CHNA notes (at 31) that "[a]lmost every Monday morning there will be 17 to 18 psychiatric patients in the emergency room waiting for placement."[3]

While UM BWMC supports the additional capacity, it opposes the setting (a special psychiatric hospital) within which AAMC seeks to provide this capacity, arguing that AAMC should be required to establish a hospital-based unit instead. UM BWMC highlights its plan to add an additional 10 beds to its 14-bed hospital based unit at some point in the future, a plan UM BWMC proposed after AAMC filed its Application for this project. While AAMC welcomes UM BWMC's belated decision to expand its inpatient unit, a psychiatric unit in the midst of an acute care general hospital is not comparable to the innovative, comprehensive mental health care facility that AAMC seeks to create, one that will optimize resources and provide a setting for patients and families that is secure, private, and dedicated entirely to the comprehensive care and treatment of persons suffering from mental illness. This concept has apparently been lost on UM BWMC.

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[2] See, e.g., http://www.wbaltv.com/article/report-reveals-availability-of-mental-health-care-in-anne-arundel-county/7099116 ("... we're actually sending out probably 800-900 patients a year to other state hospitals to find beds," said Becky Paesh with the Planning & Business Development at the University of Maryland Baltimore Washington Medical Center. See also http://www.capitalgazette.com/news/ph-ac-cn-mental-health-1004-20141004-story.html (BWMC representative discussing need for additional outpatient mental health programs in the County).

[3] The CHNA notes (at page 30) that, between 2002 and 2014 there was a 145% increase in the number of residents served by the public mental health services agency in Anne Arundel County. Of the 16 principal findings, four are related to the mental health needs of the county. In fact, one of the four chapters is devoted entirely to mental health, the epidemic crisis of heroin and opioid use, co-occurring issues (i.e., the relationship between substance use and mental health disorders) and access to substance use treatment.

Two misplaced themes pervade UM BWMC's Comments. The first is the 100% variable cost factor (VCF) that applies to special psychiatric hospitals.[4] UM BWMC claims that it would be "unfair" for AAMC to operate under a 100% VCF while UM BWMC must operate under a 50% variable cost factor as a hospital-based unit. What UM BWMC obfuscates, however, is that the 50% variable cost factor does not apply to its existing inpatient psychiatric volume that predates the Demonstration Project, and thus the full revenues should be reflected in UM BWMC's GBR.[5] The 50% VCF only applies to incremental volume since the establishment of the GBR in FY2014, including the additional beds that UM BWMC decided to pursue after AAMC filed its application for this project. Had UM BWMC not waited until after AAMC proposed this project and had instead added the additional beds before the Demonstration Project, their full revenues could have been reflected in its UM BWMC's GBR.

Additionally, the VCF applies to both volume increases and decreases in direct correlation. Over 75% of AAMC's projected volume are cases currently being transferred from AAMC's ED to Sheppard Pratt, a special psychiatric hospital that is also subject to the 100% VCF. Application, at 93. Accordingly, 100% of the revenue associated this volume will be taken out of Sheppard Pratt's rates.

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[4] UM BWMC mischaracterizes the rule applicable to special psychiatric hospitals as "full revenues" and "100% of charges." Special psychiatric hospitals are subject to rate regulation by the HSCRC but do not fall under the Maryland Demonstration model. This means that Federal payers are not required to pay HSCRC approved rates to special psychiatric hospitals. Only non-Federal Payers must pay HSCRC approved rates to these hospitals. For rate setting purposes, a special hospital's revenue is subject to a 100% variable cost factor. Medicare pays Psychiatric PPS rates to special psychiatric hospitals, which are less than what Medicare pays in a GBR hospital setting. Medicaid has historically paid special hospitals 94% of charges, but is not required to pay at this level by statute.

[5] UM BWMC obliquely acknowledges that its existing unit is not affected by the 50% VCF on page 3 of its Comments, where it claims that, with a 100% VCF, AAMC would have an advantage in staffing its mental health hospital as against the revenue UM BWMC will receive for the "expansion portion" of its unit.

UM BWMC's second theme is speculation that AAMC might decide in the future to increase the number of inpatient beds to become subject to the Institutions for Mental Disease ("IMD") exclusion. UM BWMC suggests that, if AAMC were to become an IMD, UM BWMC would be harmed because it would then be the only inpatient psychiatric care option in the County for adult Medicaid patients. Apart from being wrong in the notion that the IMD exclusion operates as a prohibition on admitting adult Medicaid patients (as will be discussed below), this is an ironic argument coming from UM BWMC given that almost never accepts inpatient psychiatric transfers from AAMC (Medicaid patients or otherwise) today. UM BWMC's argument is both misplaced and irrelevant to AAMC's Application. It is undisputed that the project proposed in the Application would not be subject to the IMD exclusion, which only applies to special psychiatric hospitals with more than 16 beds

Relying heavily on these two misplaced themes, UM BWMC claims that the Application fails to satisfy two State Health Plan standards: (1) cost effective alternative, and (2) adverse impact. As set forth in the Application and further explained below, the proposed mental health hospital represents the most cost effective alternative to meeting the critical need for additional inpatient mental health care in the County, and will have a positive impact on the health care system as a whole, and UM BWMC in particular.

ARGUMENT

1.

UM BWMC Does Not Qualify for Interested Party Status

UM BWMC seeks interested party status under COMAR 10.24.01.01B(20) claiming that the approval of the project would adversely affect its hospital-based inpatient psychiatric unit through a depletion of essential clinical staff, specifically, psychiatrists.

However, UM BWMC does not oppose AAMC establishing – and staffing – the same size unit within AAMC's acute care general hospital building, There would be no difference between the number of psychiatrist FTEs (or other clinical care staff) necessary to staff a 16-bed hospital-based unit and the proposed mental health hospital. Accordingly, because there is no difference between the clinical staffing required for the proposed mental health hospital and for the hospital-based unit that UM BWMC does not oppose, this is not a basis upon which UM BWMC should be granted interested party status.

UM BWMC also claims (at p. 3) that, with the 100% VCF, AAMC would have a "competitive advantage" in the revenues it has available to staff its mental health hospital against UM BWMC's staffing of the "expansion portion" of its hospital based unit (that is, the ten beds that it plans to add to its unit in the future). A facility is not entitled to interested party status based on its future expansion plans, particularly plans it proposed only after the application for the project at issue was filed.

Further, salary scales for clinical staff members are the same across all programs within the Anne Arundel Health System, including both inpatient and outpatient programs. There is no separate salary schedule that will apply to staff at the new mental health hospital. AAMC will not pay psychiatrists hired for the new mental health hospital on a different salary scale than applies to the liaison/consult psychiatrist serving AAMC's acute care general hospital, or any other psychiatrist in the AAHS system. The financial projections in the Application are based on the same salary scale being applied across the AAHS system. Accordingly, there is no basis for UM BWMC's claim of that AAMC would have a competitive advantage, or interested party status on this basis.

UM BWMC also argues that it would be adversely affected if the mental health hospital becomes an IMD in the future, which it claims would cause UM BWMC to be the sole provider of inpatient psychiatric care for adult Medicaid patients in the County. Interested party status must be based on the project proposed in the application, not speculation that the project might expand in the future.[6] As UM BWMC admits, the mental health hospital proposed by AAMC in the Application is not an IMD. Further, as discussed in Section 3 below, UM BWMC is wrong in suggesting that IMDs cannot admit adult Medicaid patients; to the contrary, IMDs in Maryland may admit adult Medicaid patients and are reimbursed for those admissions in accordance with the Medicaid program's guidelines.[7] Accordingly, the basis upon which UM BWMC seeks interested party status – that it would become the only inpatient psychiatric facility able to accept adult Medicaid patients in Anne Arundel County – is unfounded.

This is not an adverse impact on UM BWMC in any event because BWMC is currently the only provider of inpatient psychiatric care to adult Medicaid patients in the County. Moreover, if being the only provider of inpatient psychiatric care to adult Medicaid patients in Anne Arundel County is harmful to UM BWMC as it suggests, then AAMC's project will clearly benefit UM BWMC because AAMC's mental health hospital will be another resource for that population.

For these reasons, UM BWMC is not entitled to be an interested party in this review.

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[6] As discussed below, a CON would be required before AAMC could expand the number of beds at the facility so the Commission could fully consider the effect of the IMD exclusion at that time. The only exception to the CON requirement is for creep beds under COMAR 10.24.01.03E(2), but at 16 beds, creep beds would be limited to one bed after two years in operation. It is simply irrational to suggest that, without another waiver or other relief from the IMD exclusion, AAMC would subject itself to the IMD exclusion in order to grow by one bed.

[7] Exhibit 2 contains the process required by the Medicaid program for admitting adult Medicaid patients to an IMD.

2.

The Project is the Most Cost Effective Alternative To Addressing the Critical Need for Additional Inpatient Psychiatric Capacity in Anne Arundel County

a. The 16-Bed Inpatient Unit

UM BWMC's argument that locating the 16 beds in AAMC's acute care general hospital is more cost effective than establishing the mental health hospital is unfounded and incorrect.

AAMC considered the alternative of constructing a 16-bed inpatient unit on the 6th floor of the North Tower of its acute care general hospital. While establishing the unit in existing space within the hospital is, not surprisingly, less expensive than constructing the new building on the Pathways campus as proposed, this option fell far short on key objectives for the project.[8] In particular, while this floor could have accommodated a 16-bed inpatient unit, it cannot accommodate the partial hospitalization program and the other outpatient programs planned for the new building, and there is no space available on the hospital campus for the inpatient unit to be co-located with these programs to create the integrated, holistic mental health care program that this project represents.

Accordingly, the hospital-based option for the inpatient unit would prevent the achievement of two core goals of the project: (1) strengthen quality and continuity of mental health care in Anne Arundel County through establishing a comprehensive and integrated mental health program that enables coordination with community based support services, and (2) reduce

[8]Contrary to UM BWMC's argument, the construction cost of the new mental health hospital is not three to four times more expensive than constructing a hospital based unit. The estimated cost stated in the Application (at 82) for the hospital based option of $6.5 million to $8.5 million has not been updated because it was not the option AAMC decided to pursue. Accordingly, that cost cannot be compared to the updated cost of the Pathways project.

length of stay and admission rates, and leverage community based resources to the fullest extent possible. See Application at 80.

The clinical advantages to co-locating the inpatient unit with the outpatient programs are significant. Psychiatrists will work in both the inpatient unit as well as the partial hospitalization program, thus easing this transition for patients and avoiding the potential for gaps to arise in communication or appropriate follow-up care. Should an acute episode/relapse occur, physicians will be able to admit patients directly to the acute unit and eliminate the need for an ED visit/evaluation. The ability to accommodate direct admissions from sub-acute care programs when relapsing illness requires such an intervention will reduce unnecessary overburdening of acute hospital EDs and inconveniencing patients and families. The integration of self-help programs and family wellness programs into the work-flows and into the very work spaces of the inpatient program will encourage incorporation of this recovery-oriented approach to mental health problems. Continuity of these self-help programs and family programs across inpatient, partial hospital and outpatient environments will also promote early identification of, and timely intervention to avoid, relapse. See Application at 15-16.

The clinical advantages to co-locating the inpatient unit with these outpatient programs also drive the projected two-day reduction in the average length of stay of patients currently being transferred outside of Anne Arundel County. See Application at 57. This reduction could not be achieved without establishing the inpatient unit as part of an integrated mental health care program in a single location.

Pointing to the fact that the unit would be elevated in either location, UM BWMC argues that AAMC inconsistently graded the suitability of the two locations in its assessment of the

alternatives. UM BWMC's argument misses the mark. The issue is not elevation in and of itself, but the setting within which the unit is elevated. Locating a locked psychiatric unit within general acute care hospital settings raises safety and security concerns that are not presented when inpatient psychiatric capacity is located in a dedicated mental health treatment facility. If a unit is to be in an acute care general hospital, it is preferable for safety and security concerns to locate the unit on the first floor where it can have a controlled, separate entrance. Also, locating the unit on the first floor ensures that involuntary psychiatric patients do not need to be transported to an upper floor in elevators used for multiple other purposes and patient populations. Accordingly, the fact that the only available space in AAMC's acute care general hospital being on the 6th floor made the hospital location less suitable and effective from a safety and security standpoint as compared to the dedicated mental health facility proposed for the Pathways campus.

UM BWMC also argues that the in-hospital option is more efficient from a staffing perspective, suggesting that AAMC could utilize its existing mental health staff in the hospital to staff the psychiatric unit. This is incorrect. The level of mental health clinical staffing required for the inpatient unit is the same whether the unit is in the hospital or freestanding at the Pathways campus, and there is no will be no duplication of such staff at the two locations. The mental health clinicians in the hospital are primarily focused on assessment, and are spread across three shifts spanning 24 hours a day in the hospital. There is no capacity or opportunity for cross-training these clinicians to work in an inpatient psychiatric unit focused on therapeutic intervention and recovery. The mental health clinical staff that will most appropriately be cross trained for the inpatient unit are not the hospital-based clinicians, but the clinical staff in the

partial hospitalization program and outpatient and intensive outpatient programs that will be located at the Pathways campus.

UM BWMC suggests that AAMC's alternatives scoring matrix (Application, at page 81) recognizes that staffing is more efficient for a hospital location by giving the hospital a higher score than Pathways in that category. This is incorrect. The hospital did receive a higher score than Pathways in the category of "staffing" but this is not the category within which the opportunities for cross training staff and related clinical advantages were scored. This category refers to efficiencies in ancillary clinical services such as lab, pharmacy, phlebotomy, etc., not mental health care clinical staff. Efficiencies and clinical advantages associated with cross training the clinical staff that will provide mental health care were assessed as part of program quality, for which the Pathways location received a much higher score than the hospital.[9] However, the efficiencies associated with ancillary service staffing and support service staffing are far outweighed by the mental health clinical staff efficiencies and related patient care advantages associated with the Pathways location.

UM BWMC claims that AAMC has not accounted for all available space on the existing hospital campus. To the contrary, AAMC has accounted for all available space – there is no available space on the hospital campus for a comprehensive mental health care program that includes the inpatient unit, the partial hospitalization program and the other outpatient programs planned for the building. The 6th floor of the North Tower was a potential location for the inpatient unit alone, but there is no location on the campus for the comprehensive mental health

[9]Just as the hospital location would be more efficient from a staffing perspective in ancillary services, AAMC's scoring matrix ranks the hospital location higher than the Pathways location in "support services" staffing, such as housekeeping, security, and loading dock/receiving personnel at the hospital. It should be noted, however, there is already a kitchen at Pathways that will be shared with the new building and any additional staff needed to prepare the extra food would have had to be added at the main hospital as well

care program planned for the new building on the Pathways campus. Divorcing the inpatient unit from the partial hospitalization program and the other outpatient programs defeats the clinical advantages and shorter lengths of stay associated with co-locating these programs as described above, and would not achieve key objectives of the project.

The necessity of eliminating physical capacity for medical/surgical hospital beds on 6 North in order to accommodate a 16-bed psychiatric unit was another factor weighing against the hospital-based option. AAMC operates 48 medical/surgical beds on the 6 North, 25 of which would have to be eliminated in order to establish a locked 16-bed psychiatric unit. There is no other space in the hospital for these 25 beds, so this would represent a loss of physical bed capacity. Losing this bed capacity would cause AAMC's occupancy rate and its related ED diversion rate to return to unacceptably high levels. In FY16, including all 48 beds on 6 North, AAMC's average occupancy rate on Monday-Wednesday was 89% and its hours on ED diversion exceeded 25%. In February, 2016, AAMC's occupancy rate was over 90%, and 24 out of 29 days included ED diversion. In March, 2016, AAMC was on diversion 51% of the time.

In late September, 2016, AAMC opened 30 additional medical/surgical beds on 5 South, and this has helped to bring AAMC's occupancy rate and diversion rate back down to more effective levels. In October, 2016, AAMC had a 79% overall occupancy rate, 83% Monday-Wednesday (exceeding 85% only on Tuesdays), and its hours on diversion dropped to 8% overall. However, eliminating the 25 beds on the 6th floor would virtually wipe out the progress made with opening the 30 beds on 5 South. In October, 2016, if AAMC did not have 25 of the 48 existing beds on the 6 North, AAMC's occupancy rate would have been at the ineffective level of 90%, and its ED diversion rate back to an unacceptable level. Accordingly, while the

loss of medical/surgical bed capacity resulting from establishing a hospital-based psychiatric unit was a factor that weighed against this option in AAMC's scoring analysis, time has proven that losing this capacity would have a significant negative impact on AAMC's ability to operate effectively as an acute care general hospital.

UM BWMC argues that the loss projected for a hospital-based unit could be absorbed by AAMC without threatening AAMC's financial viability. UM BWMC misses the point. AAMC has not claimed that it could not absorb the operating loss associated with a hospital-based unit. However, the fact that a hospital-based unit would generate this level of loss makes this a less cost-effective alternative than the proposed project which does not operate at a loss and generates the clinical advantages associated with being part of an integrated mental health program in a dedicated facility at the Pathways campus as described above and in the Application.

b. The Impact of the IMD Exclusion

UM BWMC claims that AAMC did not consider the "risk" that it may not receive Medicaid reimbursement for adult Medicaid admissions. There is no such risk associated with the mental health hospital proposed in the Application because it is not an IMD. Further, as described further in Section 3 below, contrary to UM BWMC's suggestion, even when it applies, the IMD exclusion does not prohibit an IMD from admitting adult Medicaid patients. It prohibits Federal participation in the cost of the admissions, so only State funds can be used. As a result of the loss of Federal funding, the Medicaid program requires hospital EDs to first attempt to locate an available bed in a hospital-based unit; if no beds are available, the admission to the IMD is approved. See Exhibit 2.

Although AAMC's proposed mental health hospital will not be an IMD, AAMC analyzed the impact of a 50% cut in Medicaid reimbursement for adult Medicaid admissions to its mental health hospital (the level that would hold the State completely harmless from the loss of Federal funds for adult psychiatric admissions to IMDs).[10] As shown in Exhibit 3, the effect would be to generate a small annual loss, much smaller than the loss associated with operating a hospital-based unit. While this project will not be an IMD, this analysis demonstrates that even if it were, it is still a more cost effective alternative than locating the unit at the hospital.

c. Shell Space

UM BWMC argues that the shell space is not cost effective because AAMC has not justified the use of a 100% complexity factor, ignoring the detailed justification provided by AAMC arising from the high level of complexity associated with adding a new floor above an active inpatient unit in a building with critical infrastructure on the roof. The considerations are described in detail on updated Application page 78 (see August 1, 2016 Project Cost and Shell Space Updates).

The complexity associated with constructing an additional floor on top of an existing occupied health care facility is confirmed by the opinions of The Whiting-Turner Construction Company and the architectural and design firm of CR Goodman Associates attached as Exhibits 4 and 5. CR Goodman Associates summarizes the complexity justifying the 2x factor as follows (Exhibit 5, at 1):

[10] As described further in Section 3 below, since the loss of the waiver effective July 1, 2015 (FY2016), the State has not cut funding for adult inpatient admissions to IMDs to hold itself harmless from the loss of Federal funds.

> The complexity of constructing a vertical expansion above an occupied psychiatric inpatient unit will add very significant cost. Access to the unit will need to be carefully controlled and limited to certain hours. Major plumbing work as well as work on other systems will need to occur within the second floor ceiling space. In order to ligature-proof the second-floor patient rooms, non-accessible drywall ceilings will need to be installed. If a future floor were to be added at a later date, these ceilings would have to be demolished, creating further disruption and extended working time in the existing unit. Other issues that complicate future vertical expansion include maintaining the weatherproof integrity of the building throughout the construction period.

Similarly, Whiting Turner explains (Exhibit 4):

> Obviously, the cost modifications are justified for a vertical addition after occupancy in lieu of including it in the base building construction. The Whiting-Turner Contracting Co. agrees that if a 3rd floor is added to this Mental Health Hospital after the base building construction is completed it will add a substantial cost increase with several patient [and] staff disruptions.

UM BWMC argues that there is no present need for eight adolescent beds, but ignores the outpatient mental health programs for which AAMC plans to use all of the shell space in the next 3-5 years, none of which involve additional inpatient beds. These outpatient mental health programs (which are described in in detail in response to Question 3 of the June 23, 2016 completeness questions and at Updated Application Pages 78a-78b of the August 1, 2016 Project Cost and Shell Space Updates) will help to complete the continuum of mental health care to be provided within the facility. They include an intensive outpatient clinic for adolescents and children, an outpatient mental health program for pain management, and the relocation of the adult outpatient clinic from leased space at another location.

AAMC identified the possibility of an 8-bed unit for adolescents only as a possible alternative use for a portion of the shell space on the third floor (where the adult outpatient clinic is slated to be put when its lease expires) but only if the State is granted a waiver or other relief from the IMD exclusion and depending on whether there is demonstrated need at the time. See

August 1, 2016 Updated Application page 78b and Response to June 23, 2016 Completeness Question 3 (at pages 6-7).

3.

The Project Will Have a Positive Impact on the Health Care System

As set forth in the Application, the proposed project will positively impact the health care system, including (Application, at 16):

(a) Improve access, minimize the need for hospital-to-hospital transfer, and reduce delays in care for patients in crisis;

(b) Improve quality of care by providing continuity of care for patients who require ongoing treatment; maintain clinical relationships across acute and community-based treatment settings;

(c) Reduce length of stay in the acute care setting by providing alternative mental health settings in the same building, and by integrating closely with local community-based support services;

(d) Reduce the relapse rates, readmissions, and return visits to the ED, and improve long-term outcomes through the integration of substance use and medical services to patients and through more effective use of local community-based services;

(e) Involve family members in the recovery process by providing a more local service site and removing the hardship of travel that currently discourages family involvement;

(f) Produce operating efficiencies by leveraging the mental health workforce within the inpatient and outpatient programs and sharing well-trained, hard-to-recruit professionals;

(g) Become a community-oriented model for comprehensive mental health services; and

(h) Promote the training of clinicians at all levels, attract clinical research, and provide a setting for effective collaboration with social services.

UM BWMC is silent about these benefits in its Comments. Instead, UM BWMC's Comments address how it believes a project not proposed in the Application – the establishment

of an IMD -- would have a negative impact on the health care system. Although it admits the project proposed in the Application is not an IMD and that there is a need for the additional inpatient capacity in Anne Arundel County, UM BWMC argues that the Commission should nevertheless disapprove the project because of the "potential risk" that it might become an IMD in the future. There is no basis to disapprove a project as to which there is no dispute will have a positive impact on the health care system based on unfounded speculation about expansion in the future. As AAMC made clear in its Application, AAMC intends its mental health hospital to be an additional non-IMD resource for the care of Medicaid patients in Maryland in need of an inpatient psychiatric admission. See Application, at 53.

Further, UM BWMC's argument is flawed and misleading as to the current environment for IMDs in Maryland. While the Federal Medicaid program will not pay for an adult psychiatric admission to an IMD, State reimbursement for these admissions is not prohibited and, to date, the State has made up for the loss of Federal funds for these admissions with State funds. As described in the analysis by the Department of Legislative Services of the proposed budget for FY17 of the Behavioral Health Administration attached as Exhibit 3 to UM BWMC's comments[11], in FY16, the loss of Federal funds was addressed through an emergency fund transfer. In the FY17 budget, $30 million in State-only funds was appropriated for adult Medicaid admissions to psychiatric IMDs, the same level appropriated in the FY15 budget (the last fiscal year under the IMD waiver) split between State and Federal funds.[12] In order to manage costs now that these admissions are funded with State funds only, the Medicaid program

[11] Contrary to UM BWMC's claim, Exhibit 3 to UM BWMC's Comments is not an analysis prepared by the Behavioral Health Administration. The Department of Legislative Services prepared this analysis of the budget of the Behavioral Health Administration (as proposed by Governor Hogan) for the General Assembly for use in its review of the FY17 budget, just as DLS does for every executive branch agency.

[12] The funding for IMD admissions is included as part of Item M00L01.03 in the FY17 Budget Bill (excerpt attached as Exhibit 6) and Item M000L.01.02 and L.01.03 in the FY 15 Budget Bill (excerpt attached as Exhibit 7).

requires hospital EDs to first attempt to locate an available bed in a hospital-based unit, but if no beds are available, the admission to the IMD is approved. See Exhibit 2. While future State budget decisions are always subject to uncertainty, the State's level of funding since the loss of the waiver demonstrates the State's continued commitment to ensuring access to inpatient psychiatric care for adult Medicaid recipients.

Accordingly, beyond the fact that AAMC's mental health hospital is not an IMD, UM BWMC is simply wrong in its assertion that an IMD is prohibited from admitting adult Medicaid patients. Moreover, last year, after the State's loss of the IMD exclusion waiver, the Commission approved the conversion of a hospital based unit to an IMD, contrary to UM BWMC's suggestion that the establishment of an IMD is contrary to sound health planning policy. Specifically, in Docket No. 13-15-2349, the Commission approved the conversion of Washington Adventist Hospital's 40-bed hospital-based unit to a freestanding, special psychiatric hospital – an IMD -- notwithstanding the State's loss of the IMD waiver.

UM BWMC's suggestion that its Medicaid share would increase if AAMC could not admit Medicaid patients is ironic given that UM BWMC rarely accepts transfers from AAMC's ED.[13] It is also wrong. Far from demonstrating an adverse impact, UM BWMC's argument demonstrates the positive impact that this project will have on UM BWMC. If (as UM BWMC argues) being the only option for adult Medicaid admissions in Anne Arundel County is detrimental to UM BWMC, AAMC's project solves that problem for UM BWMC.

Additionally, any expansion in the number of beds in the project in the future (other than "creep" or waiver beds under COMAR 10.24.01.03E(2) would require a CON, so the

[13]It accepted no adult transfers from AAMC's ED in FY's 15 or 16.

Commission would be able to fully review the status and ramifications of the IMD exclusion on the project before expansion occurs. Further, under the waiver bed rule, at 16 beds, AAMC could only expand by one bed after two years in operation. In the absence of the State being granted another waiver or other relief from the IMD exclusion, adding a single bed would subject AAMC's mental health hospital to uncertainty surrounding Medicaid reimbursement, and make it an option for adult Medicaid admissions only when a hospital-based bed is not available. It is irrational to suggest that AAMC would decide to become an IMD with these disadvantages in order to expand by one bed. [14]

UM BWMC also claims that the project will adversely impact the health care system through higher costs as a result of the 100% VCF that applies to special psychiatric hospitals. To the contrary, AAMC's mental health hospital will provide a lower-cost alternative for inpatient psychiatric care and reduce the per capita costs of specialty care for Maryland residents by shifting volume from higher cost facilities to AAMC's mental health hospital. The average payment per case at AAMC's mental health hospital will be 33% below the statewide average, and 43% lower relative to Sheppard Pratt, where 75% of these patients are currently receiving inpatient care, producing a $3.3 million savings to the health care system each year. The average charge per case at AAMC's mental health hospital will be 18% lower than UM BWMC's average charge per case.[15] See Application, at 97-98.

Finally, the VCF applies to both volume increases and decreases in direct correlation. Cases now being transferred from AAMC's ED to Sheppard Pratt constitute over 75% of the

[14] AAMC opposes the condition requested by UM BWMC that would prohibit AAMC from using the waiver bed rule to expand in the future. There is no precedent or statutory authority to prohibit the addition of waiver beds, which are authorized by Health-General Article §19-120(h)(2)Ii) without a CON.

[15] As described above, the 50% VCF to which UM BWMC suggests it is subject has no application to its existing inpatient unit. Predating the Demonstration Model, its GBR should incorporate all of the revenues associated with this unit.

projected volume of the mental health hospital. Application, at 93. Sheppard Pratt is a special psychiatric hospital that is also subject to the 100% VCF. Accordingly, 100% of the revenue associated this volume will be removed from Sheppard Pratt's rates.

CONCLUSION

UM BWMC is not entitled to interested party status because it has not demonstrated that AAMC's mental health hospital will adversely affect its hospital-based inpatient psychiatric unit through a depletion of essential clinical staff or in any other way. UM BWMC has demonstrated that it will be benefitted by the project because UM BWMC would no longer be the only provider of inpatient psychiatric care to the adult Medicaid population in Anne Arundel County if the project is approved.

Even if UM BWMC is granted interested party status, its Comments lack merit and fail to demonstrate a basis upon which to conclude that the project is not consistent with State Health Plan requirements. This project will enable AAMC to deliver a comprehensive and integrated mental health care program on a single campus that will incorporate inpatient psychiatric care, psychiatric partial hospitalization and other outpatient mental health care programs along with referral and care coordination to community based support services to meet a critical need for these services in Anne Arundel County. The project meets all applicable State Health Plan standards and criteria, and should be approved.

Respectfully submitted,

Marta D. Harting

Marta D. Harting
Venable LLP
750 E. Pratt Street, Suite 900
Baltimore Maryland 21202

Counsel for Anne Arundel Medical Center

CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of December, 2016, a copy of the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center was mailed, postage prepaid to:

Thomas C. Dame, Esq.
Ella R. Aiken, Esq.
Gallagher Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, MD 21201

and

Jinlene Chan, M.D., M.P.H.
Health Officer
Anne Arundel County Department of Health
3 Harry S. Truman Parkway
Annapolis MD 21401

Marta D. Harting

Marta D. Harting

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Joshua E. Jacobs
Vice President, Strategic Planning &
Marketing/Communications
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Lucas Klock
Director, Capital Projects
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Barbara Jacobs, MSN, RN-BC
Chief Nursing Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Miriam Suldan
Senior Managing Consultant
Berkeley Research Group, LLC

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Valerie Lehman
Manager,
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

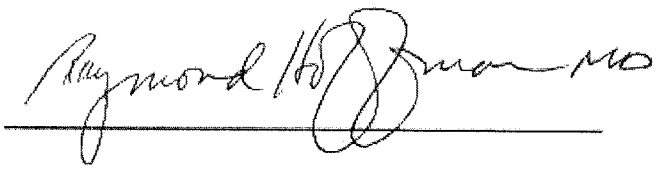
Dated: December 1, 2016

Dawn Hurley
Executive Director of Behavioral Health
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016



Raymond Hoffman, MD
Medical Director, AAMC Division of Mental Health
and Substance Use
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Victoria W. Bayless
President & Chief Executive Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Bob Reilly
Chief Financial Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Response to Comments of University of Maryland Baltimore Washington Medical Center are true and correct to the best of my knowledge, information and belief.

Dated: December 1, 2016

Jeanette Cross
Managing Director
Berkeley Research Group, LLC

EXHIBIT 1

UM Baltimore Washington Medical Center
Psychiatric Discharges by Admission Source
Fiscal Year 2016

		Discharges by Admitting Facility / Source							
		Specialty / Acute	Skilled Nursing Home		Other				
Admission Source Code		Sheppard Pratt	Bay Ridge Health Care Center	North Arundel Health And Rehabilitation Center	Other Facility	Other BWMC Unit	Home	Unknown	Total
26	Transfer from On-Site Acute Care to On-Site Psych	-	-	-	-	44	-	-	44
27	Transfer from On-Site Psych Unit to Acute Care	-	-	-	-	2	-	-	2
28	Transfer from On-Site Sub-Acute to Acute Care	-	-	-	-	10	-	-	10
43	Admit from Private Psych Hospital or Unit of Another Acute Facility	1	-	-	-	-	-	-	1
47	Admit from Supervised / Congregate House	-	-	-	8	-	-	-	8
51	Admit from a Skilled Nursing Facility	-	1	1	-	-	-	-	2
60	Admit from Home	-	-	-	-	-	648	-	648
99	Unknown	-	-	-	-	-	-	1	1
	Total	**1**	**1**	**1**	**8**	**56**	**648**		**716**

Notes:
[1] Source: HSCRC abstract data; FY 2016 final
[2] Inpatient only
[3] Psychiatric DRGs defined as 750-760 and 779-790
[4] Includes patients age 18+ only

EXHIBIT 2

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

August 24, 2015

Dear Colleague:

We are writing to bring to your attention recent changes to the Department of Health and Mental Hygiene's (the Department) process for admitting adult psychiatric patients to Institutions for Mental Diseases (IMDs) within the Public Behavioral Health System.

For the past three years, the Department has participated in a Medicaid Emergency Psychiatric Demonstration that made Medicaid funds available to private free standing psychiatric hospitals (IMDs) for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64.[1] These IMDs include, but are not limited to, Sheppard Pratt, Adventist Behavioral Health, and Brook Lane.

This three-year federal demonstration ended on June 30, 2015, and effective July 1, 2015, all adult psychiatric admissions to IMDs must now be paid with state general funds only. The state general funds budgeted for adult admissions to IMDs is significantly lower than the cost projected for fiscal year 2016. Therefore, for all adults presenting to an acute care general hospital Emergency Department (ED), in need of an inpatient psychiatry admission, every effort will be made to admit the individual to an Acute Care General Hospital. To accomplish this, all acute care general hospitals will be instructed to participate in and use the Maryland Psychiatric Bed Registry. All EDs will need to use the Bed Registry to find the nearest acute care general hospitals with an open psychiatric bed and coordinate the admission with the receiving hospital and VO. Please advise your admissions department to work collaboratively with acute care general hospitals and VO to divert Medicaid admissions to any open acute care general hospital psychiatry unit bed, whenever possible.

If the ED is unsuccessful in admitting the patient to their own or another acute care general hospital using the Bed Registry, the ED must call no less than four (4) acute care general hospitals to find an open psychiatric bed prior to requesting authorization from VO for admission to an IMD. If these calls have not been completed, VO will instruct the ED to attempt to admit the patient to an acute care general hospital by making these calls before it will authorize admission to an IMD. Ultimately, admissions to IMDs will be considered as a last resort in situations where no community hospital psychiatric bed is available and emergency psychiatric inpatient treatment is indicated.

We understand that this change is difficult for these organizations. Please note that the Department is seeking a federal waiver from the IMD Exclusion. If approved by the Centers for Medicare and Medicaid Services (CMS), Maryland would have the ability to reimburse IMDS for the treatment of Medicaid enrollees aged 21-64 with acute psychiatric and substance-use-related needs and would receive federal

[1] The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the Affordable Care Act. The District of Columbia and 11 states, including Maryland were selected to participate in the Demonstration.

matching dollars. A copy of the waiver application and supporting documentation can be accessed at: http://dhmh.maryland.gov/SitePages/IMD%20Exclusion%20Waiver.aspx

Moreover, CMS is seeking public comment on Maryland's waiver application until September 11, 2015. We encourage you to submit comments here: https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1878723

Should you have any questions or concerns regarding this policy, please contact Dr. Zereana Jess-Huff, CEO to ValueOptions, Inc., Maryland by dialing 410-691-4000 or Zereana.jess-huff@valueoptions.com.

Sincerely,

Gayle Jordan-Randolph, M.D.
Deputy Secretary
Behavioral Health

Shannon McMahon
Deputy Secretary
Health Care Financing

EXHIBIT 3

AAMC Mental Health
Inpatient & Partial Hospitalization Combined
Medicaid Payments at 50% of HSCRC Approved Rates

	FY2019 [19]	FY2020	FY2021	FY2022	FY2023
Annual Inpatient Psych Cases	718	879	886	892	892
Average Daily Census	12.1	14.8	14.9	15.0	15.0
% Volume Change		*22.4%*	*0.8%*	*0.7%*	*0.0%*
Mental Health Partial Hospitalization Program	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**
PHP Visits (Pathways only)	4,229	5,679	5,718	5,758	5,799
Revenue					
Gross Patient Revenue [1]	$7,719,154	$9,858,247	$10,123,007	$10,384,868	$10,600,670
Variable Cost Factor [2]	$0	$0	$0	$0	$0
Total Gross Revenue	7,719,154	9,858,247	10,123,007	10,384,868	10,600,670
Deductions from Revenue [3]	(2,922,677)	(3,710,353)	(3,810,243)	(3,908,838)	(3,988,307)
Net Patient Revenue	4,796,477	6,147,893	6,312,764	6,476,031	6,612,362
Collected Physician Fees [4]	293,648	367,732	374,284	380,536	384,631
Net Revenue	**$5,090,126**	**$6,515,625**	**$6,687,048**	**$6,856,567**	**$6,996,993**
Expenses					
Staff Compensation [5]	3,306,316	3,542,486	3,613,336	3,685,602	3,759,314
Physician Compensation [5]	665,427	721,381	735,809	750,525	765,535
General Support Staff Compensation [6]	920,867	926,457	932,159	937,974	943,906
Drugs [7]	93,845	117,186	120,482	123,724	126,198
Medical & Non-Medical Supplies [7]	100,099	132,356	136,032	139,665	142,600
Other Expenses [8]	216,321	243,188	248,044	252,997	258,049
Patient Transport [9]	12,920	16,408	16,737	17,071	17,413
Contracted Services [10]	133,646	214,950	194,766	199,644	204,644
IS Operating Costs [11]	95,877	113,601	115,873	118,191	120,555
Staff Recruitment [12]	30,000	30,600	31,212	31,836	32,473
Staff Training & Orientation [13]	33,407	34,075	34,757	35,452	36,161
Program Accreditation [14]	29,000	4,000	4,000	14,000	4,000
Depreciation [15, 16]	623,529	631,980	631,980	624,620	624,620
Total Expenses	**6,261,254**	**6,728,669**	**6,815,184**	**6,931,300**	**7,035,468**
Net Income	**$ (1,171,128)**	**$ (213,044)**	**$ (128,136)**	**$ (74,733)**	**$ (38,475)**
% Total Margin	**-23%**	**-3%**	**-2%**	**-1%**	**-1%**

CASH FLOWS:	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Net Income		$ (1,171,128)	$ (213,044)	$ (128,136)	$ (74,733)	$ (38,475)
Depreciation		623,529	631,980	631,980	624,620	624,620
Capital - Building [17]	(24,984,795)	-	-	-	-	-
Capital - Information Systems [18]	(229,900)					
Year-End Cash Flow	**$ (25,214,695)**	**$ (547,600)**	**$ 418,936**	**$ 503,844**	**$ 549,886**	**$ 586,145**

Payback Period (years)	**43**
ROI - 3 years	**-98.5%**
ROI - 5 years	**-94.0%**

EXHIBIT 4

G. W. C. WHITING
(1883-1974)

WILLARD HACKERMAN
(1918-2014)

TIMOTHY J. REGAN
PRESIDENT AND CEO

FOUNDED 1909

THE WHITING-TURNER CONTRACTING COMPANY

ENGINEERS AND CONTRACTORS

CONSTRUCTION MANAGEMENT
GENERAL CONTRACTING
DESIGN-BUILD
SPECIALTY CONTRACTING
PRECONSTRUCTION
BUILDING INFORMATION MODELING
INTEGRATED PROJECT DELIVERY

300 EAST JOPPA ROAD
BALTIMORE, MARYLAND 21286
410-821-1100

INSTITUTIONAL
COMMERCIAL
CORPORATE
TECHNOLOGY
INDUSTRIAL/PROCESS
INFRASTRUCTURE
SUSTAINABILITY

November 29, 2016

To Whom It May Concern,

There are several reasons for increased construction costs when adding a vertical addition onto an existing occupied facility. A few include:

- Added mobilization for subcontractors, equipment, cranes, etc.
- Lump sum material & equipment costs that could have been included in the base building construction
- Patching existing roof systems and other waterproofing building envelope barriers
- Extended warranties on roofs, mechanical equipment, etc. that were affected by construction
- Tie-ins and additions to existing systems where provisions could have been set in place if part of the base building construction. This includes but is not limited to plumbing risers, mechanical shafts, sprinkler risers, electrical rough-ins, structural steel, etc.
- Off hours work for MEP tie-ins, etc. in order to minimize the effects on the current tenant which adds premium time to labor costs
- A prolonged project schedule due to site coordination and logistics

Obviously, the cost modifications are justified for a vertical addition after occupancy in lieu of including it in the base building construction. The Whiting-Turner Contracting Co. agrees that if a 3rd floor is added to this Mental Health Hospital after the base building construction is completed it will add a substantial cost increase with several patient & staff disruptions.

Sincerely,

Kyle Turner
Project Manager
The Whiting-Turner Contracting Company

EXHIBIT 5

CRGoodmanAssociates
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

29 November 2016

Mr. Lukas Klock
Director, Capital Projects
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Maryland 21401

Re: Certificate of Need Response Support Letter
Mental Health Hospital
Anne Arundel Medical Center
Annapolis, Maryland
CRGA Project No. 15.129.B, File No. 5.03

Dear Luke:

In response to your request, we hereby offer the following supporting documentation justifying the 2x complexity factor for designing the third-floor later as a vertical addition to a then existing building, rather than during the initial design and construction of the project.

General:
The complexity of constructing a vertical expansion above an occupied psychiatric inpatient unit will add very significant cost. Access to the unit will need to be carefully controlled and limited to certain hours. Major plumbing work as well as work on other systems will need to occur within the second-floor ceiling space. In order to ligature-proof the second-floor patient rooms, non-accessible drywall ceilings will need to be installed. If a future floor were to be added at a later date, these ceilings would have to be demolished, creating further disruption and extended working time in the existing unit. Other issues that complicate future vertical expansion include maintaining the weatherproof integrity of the building throughout the construction period.

Code Revisions:
The building is currently designed for compliance with the following major applicable codes:

2015 International Building Code
2015 International Mechanical Code
2015 NFPA 101 Life Safety Code
2014 Guidelines for the Design and Construction of Health Care Facilities

Depending upon the schedule for design and construction of the third floor fit-out, some or all of these codes may have been modified at that time. The International Code Council codes and NFPA codes are modified and reissued every three years. The Guidelines are modified and reissued every four years. Accordingly, new code research and associated additional fee will be required for this effort.

Changes to existing zoning, building, and fire codes could impact the ability to vertically expand the building in the future.

Building Permit Submission:
The subsequent construction of a third floor addition will require a new building permit submission, and subsequent response to any review comments received. Additional fee will be required for this separate effort as opposed to submitting the third floor as part of the overall project building permit submission.

Construction Administration Phase Services:
Additional fee will be required for all the routine services required during this phase of construction, as opposed to providing those same services during the construction of the remainder of the building. Separate submittals will need to be reviewed, separate applications for payment will require review and approval, and attendance at additional progress meetings will be needed.

Demolition Plans:
Construction of the third floor at a later date will require the development of demolition drawings and specifications for work that will need to be removed to facilitate the fit out of the third floor. This work will include minor demolition on the third floor at elevator lobbies and smoke compartment partition, as well as ceiling demolition, and removal and relocation of existing HVAC, sprinkler, fire alarm and lighting that was required by code for the shell space, but must be removed for construction of the fit out.

ICRA and ILSM Plans:
Infection Control Risk Assessment (ICRA) and Interim Life Safety Measures (ILSM) drawings and specifications will need to be prepared since the construction of a third floor vertical expansion will now occur in an occupied health care facility.

Specifications Revisions:
If any new products are selected, specifications will need to be prepared for those new products. Similarly, if any previously specified products are no longer available or desired, those specifications will need to be modified as well.

Roof Plan Revisions:
The relocation of roof-top equipment will need to be carefully coordinated to allow the existing building to remain in service. A new roof plan and associated construction details will be required. The third floor HVAC unit will need to be added if not provided under the base construction.

Structural Coordination:
In addition to design the structural system of the vertical addition, some modifications might be required to the existing building roof if floor slab depressions are required for showers and similar areas requiring slopes for drainage. Also there is a possibility that new roof openings might be required for additional mechanical duct shafts.

Sanitary Piping Revisions:
Since the final program and floor plan design is unknown at this time, it is possible that sanitary piping work will be required above the second floor ceiling and below the third floor slab. The amount of any plumbing modifications in the ceiling of the second floor is completely dependent on the third floor plan and how this plan locates bathrooms and other plumbing fixtures. This work will require a field survey to confirm existing conditions, subsequent design of new systems, and potential modification of existing mechanical, electrical, and plumbing systems in this existing interstitial zone.

Building Low Voltage Control and Fire Safety Systems:
The building automation system, fire alarm system, and security/access control systems will require expansion and recommissioning when the third floor functions are added to the system. Depending on the time frame between the completion of the base building construction and the construction of the third floor fit out system, hardware upgrades could be required. The fire suppression system will also require modifications, re-inspection and retesting when the third floor is fit out.

We trust that the above documentation will help support your complexity factor conclusion. If additional documentation is needed, kindly contact us at your earliest convenience.

Sincerely,
CR Goodman Associates

Mark E. Hasslinger, AIA
Associate Principal

EXHIBIT 6

Chapter 462

(Senate Bill 170)

Budget Bill

(Fiscal Year 2015)

AN ACT for the purpose of making the proposed appropriations contained in the State Budget for the fiscal year ending June 30, 2015, in accordance with Article III, Section 52 of the Maryland Constitution; and generally relating to appropriations and budgetary provisions made pursuant to that section.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That subject to the provisions hereinafter set forth and subject to the Public General Laws of Maryland relating to the Budget procedure, the several amounts hereinafter specified, or so much thereof as shall be sufficient to accomplish the purposes designated, are hereby appropriated and authorized to be disbursed for the several purposes specified for the fiscal year beginning July 1, 2014, and ending June 30, 2015, as hereinafter indicated.

PAYMENTS TO CIVIL DIVISIONS OF THE STATE

A15O00.01 Disparity Grants	
General Fund Appropriation	135,797,164
A15O00.02 Teacher Retirement Supplemental Grants	
General Fund Appropriation	27,658,662

SUMMARY

Total General Fund Appropriation	163,455,826

GENERAL ASSEMBLY OF MARYLAND

B75A01.01 Senate	
General Fund Appropriation	12,306,836
B75A01.02 House of Delegates	
General Fund Appropriation	22,675,984
B75A01.03 General Legislative Expenses	
General Fund Appropriation	1,018,876

Funds are appropriated in other agency budgets to pay for services provided by this program. Authorization is hereby granted to use these receipts as special funds for operating expenses in this program.

M00L01.02 Community Services		
General Fund Appropriation	148,027,593	
Special Fund Appropriation	26,919,354	
Federal Fund Appropriation	61,502,385	236,449,332

Funds are appropriated in other agency budgets to pay for services provided by this program. Authorization is hereby granted to use these receipts as special funds for operating expenses in this program.

M00L01.03 Community Services for Medicaid State Fund Recipients		
General Fund Appropriation		57,149,562

SUMMARY

Total General Fund Appropriation	218,911,728
Total Special Fund Appropriation	26,992,804
Total Federal Fund Appropriation	65,130,002
Total Appropriation	311,034,534

THOMAS B. FINAN HOSPITAL CENTER

M00L04.01 Services and Institutional Operations		
General Fund Appropriation	18,138,793	
Special Fund Appropriation	1,330,893	19,469,686

REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS – BALTIMORE

M00L05.01 Services and Institutional Operations		
General Fund Appropriation	11,569,922	
Special Fund Appropriation	1,980,671	

EXHIBIT 7

Chapter 143

(Senate Bill 190)

Budget Bill

(Fiscal Year 2017)

AN ACT for the purpose of making the proposed appropriations contained in the State Budget for the fiscal year ending June 30, 2017, in accordance with Article III, Section 52 of the Maryland Constitution; and generally relating to appropriations and budgetary provisions made pursuant to that section.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That subject to the provisions hereinafter set forth and subject to the Public General Laws of Maryland relating to the Budget procedure, the several amounts hereinafter specified, or so much thereof as shall be sufficient to accomplish the purposes designated, are hereby appropriated and authorized to be disbursed for the several purposes specified for the fiscal year beginning July 1, 2016, and ending June 30, 2017, as hereinafter indicated.

PAYMENTS TO CIVIL DIVISIONS OF THE STATE

A15O00.01 Disparity Grants

General Fund Appropriation, provided that $1,000,000 of this appropriation made for the purpose of a disparity grant to Baltimore City may not be expended until Baltimore City submits to the Department of Legislative Services the Uniform Financial Report and audit report for fiscal 2014, 2015, and 2016. Funds restricted pending receipt of these reports may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the reports are not submitted to the Department of Legislative Services.

Further provided that $1,500,000 of this appropriation made for the purpose of a disparity grant to Baltimore City may not be expended until Baltimore City submits a report demonstrating that the funding which Baltimore City received for the Maryland Center for Veterans Education and Training has been provided to the center. The report shall be submitted to the

and Mental Hygiene submits a report to the budget committees outlining the recommendations made by the department's security review of the State–operated psychiatric hospitals, how the department will implement those recommendations, and what barriers to implementation exist, including those of a legislative, regulatory, or resource–based nature. The report shall be submitted by July 1, 2016, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted..... 16,991,211

Special Fund Appropriation 61,090

Federal Fund Appropriation 4,594,280 21,646,581

Funds are appropriated in other agency budgets to pay for services provided by this program. Authorization is hereby granted to use these receipts as special funds for operating expenses in this program.

M00L01.02 Community Services

General Fund Appropriation 145,106,272

Special Fund Appropriation 35,644,870

Federal Fund Appropriation 70,838,798 251,589,940

Funds are appropriated in other agency budgets to pay for services provided by this program. Authorization is hereby granted to use these receipts as special funds for operating expenses in this program.

M00L01.03 Community Services for Medicaid State Fund Recipients

General Fund Appropriation 63,562,437

SUMMARY

Total General Fund Appropriation 225,659,920

General Fund Appropriation		2,112,306
Special Fund Appropriation		–2,112,306

21. M00L01.03 Community Services for Medicaid State Fund Recipients

To become available immediately upon passage of this budget to supplement the appropriation for fiscal year 2016 to provide funds to be used for inpatient hospital services.

Object .08 Contractual Services	1,000,000	
Federal Fund Appropriation		1,000,000

22. M00L01.03 Community Services for Medicaid State Fund Recipients

To become available immediately upon passage of this budget to supplement the appropriation for fiscal year 2016 to provide funds to be used for behavioral health provider reimbursements.

Object .08 Contractual Services	908,444	
General Fund Appropriation		908,444

23. M00L01.03 Community Services for Medicaid State Fund Recipients

In addition to the appropriation shown on page 60 of the printed bill (first reading file bill), to provide additional funding for placements at Institutions for Mental Disease (IMD).

Object .08 Contractual Services	3,000,000	
General Fund Appropriation		3,000,000

24. M00Q01.03 Medical Care Provider Reimbursements